of $5,100 for every man, woman, and child in America. In every Federal prison, we spend an average of $3,800 for every prisoner. On every Indian reservation, we will spend $1,900 total for every man, woman, and child, one half of what we spend for Federal prisoners. So it is no wonder that people die at a rate hundreds of times greater on the reservation than they do anywhere else.

America is obligated, by law and by treaty, to provide free health care for American Indians—a commitment the U.S. Government made to the Indian people in exchange for their lands. America is not honoring that commitment.

The White House's budget this year included only $2.1 billion for IHS clinical services. That is more than 60 percent below the bare minimum needed to provide basic health care for people already in the IHS system.

The problems run still deeper. Even when both groups have roughly the same insurance coverage, the same income, the same age and the same health conditions, minorities receive less aggressive and less effective care than white Americans.

The racial and ethnic disparities in our health care system are not merely a minority issue or a health care issue. The high incidence of diabetes, asthma and other diseases among minorities as a result of this health care gap costs our Nation billions of dollars every year.

But most importantly it is a moral issue. A health care system that provides lesser treatment for minorities offends every American principle of justice and equality. We have been promised that we would address these issues at some point in the future, but we have seen no action whatsoever. We have attempted to pass the Healthcare Equality and Accountability Act of 2003, and no action has yet been taken.

This legislation would reduce health disparities and improve the quality of care for racial and ethnic minorities. The bill would expand health coverage by expanding eligibility and streamlining enrollment in Medicaid and the State Children's Health Insurance Program; it would remove language and cultural barriers by providing additional funding for cultural and language services; it would offer incentives to improve health workforce diversity; it would offer new funding to State, local, and tribal initiatives that take innovative approaches to reducing the disparities; and it would increase minority health research and data collection.

The bill would also strengthen and hold accountable the government institutions responsible for ensuring health care equity. And finally, the bill would provide adequate funding for the Indian Health Service—so that we can finally reach some adequate funding level and stop the shameful underfunding of Indian health needs.

This legislation would represent a strong first step, moving us closer to the goal of ensuring equal access to quality health care.

Last year, the majority leader said:

Inequity is a cancer that can no longer be allowed to fester in health care.

I agree completely. We know what happens when cancer is allowed to spread.

Too many Americans in minority communities have lost their lives because they are subjected to a two-tiered health care system that keeps them from getting the care they need. We cannot afford to wait any longer to confront the minority health gap in our country. Americans are asking for our leadership on a challenge that is quickly becoming a national emergency. We have an obligation to answer their call.

I yield the floor.

MEDICAL MALPRACTICE CLOTURE VOTE

Mr. BYRD. Mr. President, yesterday, for the third time in this Congress, the Senate failed to invoke cloture on the motion to proceed to a one-sided, take-it-or-leave-it medical malpractice bill.

Last year, the majority leader tried to bring up a comprehensive bill. The Senate did not invoke cloture. Rather than sit down with the other side to craft a reasonable bill that could be brought up, debated, and amended, the majority leader took the same flawed bill, applied it to only one sector of the health industry, and attempted to bring it up again, just a few weeks ago.

At that time, I voted for cloture, not because I agreed with the underlying legislation, but because I had hoped for a legitimate debate, a serious look at the issues that are part of the growing medical malpractice crisis. I recognize that there are serious problems with medical malpractice in this country, and specifically with the availability of OB/GYN services in my home State of West Virginia. I voted to end debate on the motion to proceed to that bill. But, again, cloture was not invoked.

After two unsuccessful cloture votes, one would think that, if they truly wanted to pass legislation on this important issue, the Republican leadership would sit down with their Democratic colleagues and negotiate a bill that was less partisan. But there has been no such effort. Instead, the majority continues to add physician groups here and there, trying to rack up more political points. This is not a serious effort to address a real challenge. This series of votes is not designed to advance legislation. Instead, this is choreographed political theater, played for the benefit of core supporters of the Republican party. This is not a successful strategy for advancing legislation, or for solving serious problems facing our Nation, and I can not lend my support to this charade.

I do hope that the Senate can reach a consensus on this issue. Doctors and, most importantly, patients need stability in this system and the peace of mind that comes with a reliable, high-quality health care system.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER (Mr. CHAMBLISS). Morning business is now closed.

PENSION FUNDING EQUITY ACT OF 2004—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of the conference report to accompany H.R. 3108, which the clerk will report.

The legislative clerk read as follows:

The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill, H.R. 3108 to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to temporarily replace the 30-year Treasury rate with a rate based on long-term corporate bonds for certain pension plan funding requirements and other provisions, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The conference report is printed in the proceedings of the House of the RECORD of April 1, 2004.)

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. It is my understanding there are 4 hours equally divided; is that correct?

The PRESIDING OFFICER. That is correct.

Mr. GREGG. This is an important piece of legislation which deals with the solvency of a large number of companies and benefits that are paid to those companies' employees. The core, the essence of this bill is the fact that traditionally, companies have been required to fund their defined benefit plans in relationship to the rate of return that is accounted for on a 30-year Treasury bond. That affects how much money they must pay into these plans.

Unfortunately, for companies that have such plans, the 30-year bond no longer exists as a viable benchmark. That is because we as a government are not issuing 30-year bonds. Therefore, when people value a 30-year bond, it has become, in the last few years, an understated value. It is not reflecting what the true interest is, the true rate of return is, in the marketplace any longer.

If we continue to use the 30-year bond as a benchmark, an inflated payment is required by those companies which come under this rule.

The effect of that is a large amount of money—it is estimated to be $80 billion—would flow inaccurately or inappropriately as a result of the fact that the decision as to that payment is